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Office of Health Promotion
Ministry of Health

PROVINCIAL KEY-INFORMANT SURVEY ON WOMEN'S HEALTH

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OFFICE OF
HEALTH PROMOTION

EXECUTIVE SUMMARY

The purpose of this paper is to report the findings of a provincial key-informant survey. This paper also identifies and discusses in some detail several key women's health issues and begins the process of building consensus on priorities for action for women's health needs.

The key-informant survey asked the respondents to identify what they considered to be the key women's health issues and what needed to be done when addressing women's health. It is, however, only a first step in the identification of a provincial women's health needs.

An open-ended format of inquiry was used. Survey questions were based on those found in the Issues and Priorities for Women's Health in Canada: a Key Informant Survey (1986). There was some indication from the survey that there are people throughout the province who are actively involved in women's health concerns. Those who were interviewed provided many valuable ideas and opinions about women's health.

The three issues repeatedly stated are reported in the paper (family violence, reproductive health and mental health). Participants suggestions are collated and expanded in these three areas.

The key-informants expressed an overall concern that women's health needs are not adequately served by the present health care system. Problems include the overuse of technology and drugs, fragmented care and lack of control on the part of the woman. To effectively promote the health of women, it is necessary, however, to go beyond the sphere of an individual's ability to cope. The participants suggested that action such as:

- placing a priority on health policy that positively impacts women's health;
- focusing on prevention and health promotion;
- promoting active participation by women by developing services for women;
- increasing community awareness of the inter-relationship and inter-connection between women's health policy and other social policies aimed at improving women's status (e.g. child care, housing, wages and income maintenance, education, transportation, etc) and working to positively change these relationships; and

- using an multi-sectoral approach to health promotion, including dealing with systemic biases toward women, especially Native, immigrant, disabled women and young single mothers (e.g. education, wages, langauge, etc.).

In conclusion, participants identified several suggestions (Appendix 6) regarding immediate provincial priorities in women's health issues. They include:

- clarifying factors affecting women's health and identifying high risk populations (e.g. abusers);
- increasing awareness of women's health needs within the health care system;
- improving the quality of health services in meeting women's health needs, especially related to family violence, reproductive health and mental health;
- improving coordination and communications in responding to women's health needs;
- improving funding for projects which have demonstrated success; and
- building consensus on priorities for inter-ministerial action to improve women's health.

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WOMEN'S HEALTH
KEY-INFORMANT SURVEY

INTRODUCTION

In May, 1990, the Office of Health Promotion, Ministry of Health initiated an outreach process to begin to identify key issues and to build "consensus" on priorities for action in the area of women's health. This process was initiated because there was no report focused solely on women's health and their health roles from the perspective of this province. It was also felt that the results of the study would help increase awareness of the need for women's health policy in other parts of the Ministry.

A masters co-op student from the School of Public Administration, University of Victoria was hired and requested to gather information and ideas about women's health issues. The student is also a health professional. In addition, the Women's Health Committee of the Ministry was asked to provide guidance and support for the project. The Committee is made up of management staff from the Policy, Planning and Legislation Branch. The chairperson is also the provincial representative on the Federal/ Provincial/ Territorial Working Group on Women's Health. After several discussions with committee members, it was decided that a key-informant survey would be the primary source of data collection.

People throughout the province have been actively involved in women's health concerns for some time and have valuable ideas and opinions to share. The key-informant survey was conducted to obtain some broad-based input on women's health issues. The survey involved listening to what communities leaders had to say about relevant health issues facing women and what they thought should be done to improve women's health. To continue building consensus, a follow-up study, using a broad-based consumer group, should also have been done. The follow-up was not conducted, however, because of time limitations of the student's co-op placement.

Rather than discussing all aspects of the survey findings, this report presents a comprehensive review of the three most frequently mentioned issues - family violence, reproductive health and mental health.

SURVEY DESCRIPTION

The key-informant survey was undertaken between August and September, 1990. It consisted of 37 interviews with individuals from various regions of the province. The questions for this survey are provided at the beginning of Table 1 and Appendices 1-4, respectively. A set of questions developed by Health and Welfare Canada (cited in the report Issues and Priorities for Women's in Canada: a Key Informant Survey, 1986, p. 18-22) were adapted, based on the instructions of Dr. Wolczuk. Before the interview process began, several of the Women's Health committee members were asked to review the questions. They were also asked to say whether the questions would be suitable for the purpose proposed - identification of issues and beginning an iterative process to build consensus on women's health issues from the perspective of British Columbia. The open-ended format to each question ensured comparability among responses; and it also allowed a broad range of ideas and opinions to be elicited at the same time.

The thirty-seven key-informants were selected to fit one of three groups: ten were decision-makers (politicians, bureaucrats and senior health administrators); ten were professionals/ academics/ experts; and seventeen worked with community special interest groups. To ensure a provincial perspective, individuals were also selected from different regions of the province. The regions and number from each region were as followed: twelve from Greater Vancouver, nine from Victoria, and four from each of the remaining regions: the North, Vancouver Island, the Fraser Valley, and the Interior. The selection took into account the settings and specific knowledge, as well as the credibility and degree of expertise of the informants. Eighteen were interviewed face-to-face, while 19 were interviewed by telephone. The two methods of interviewing were used because of time, the size of the province and the cost of face to face interviews.

The interviews took place between August and September, 1990. Each interview was approximately an hour long and was based on the following:

- key health issues and problems for women;
- health determinants underlying women's health;
- changes necessary to improve women's health;
- programs and services that make a difference; and
- potential priorities for women's health.

Because of the limited sample size, not all aspects of women's lives were addressed (e.g. incarcerated women and lesbian women). A variety of issues were raised. The most frequently cited were: family violence (36), reproductive health (27) and mental health (25). Please see Table 1 on the next page.

Rather than reviewing all of these issues, the next section concentrates on the three most frequently stated issues. This approach is used to further illustrate the need for women's health focus, rather than concentrating the discussion on women's health issues per se. The 'Survey Findings' centre, therefore, on the issues of family violence, reproductive health and mental health.

Teen pregnancy is the focus of reproductive health. One reason for this is to illustrate the need for a comprehensive health care services approach. Another was the degree of concern expressed by the key-informants about the futures of these young women and their children.

Most of the major survey findings are included as they relate to the specific issue being discussed. A complete data set of overall responses for each question is provided in Table 1 and Appendices 1-4, respectively (Appendix 1 - Health Determinants for Women; Appendix 2 - Changes Needed to Improve Women's Health; Appendix 3 - Successful Women's Health Programs; and Appendix 4 - Priorities for Women's Health. Following the survey's findings, conclusions about a direction for women's health within the Ministry of Health are outlined.

TABLE 1

MOST FREQUENTLY STATED ISSUES

BROAD CATEGORIES	SPECIFIC ISSUES	TOTAL RESPONSES
Family Violence	(child sexual abuse; violence against women; elder abuse)	31
	Violence in general	1
	Family Dysfunctions	4
	TOTAL	**36**
Reproductive Health	Reproductive choice (abortion)	8
	Teen Pregnancy	6
	Education for birth control	5
	Reproductive technology	3
	Midwifery	2
	Rates of Cesarian Section	1
	Adoption and return of children	1
	TOTAL	**27**
Mental Health	General Mental Health	12
	Stress related to dual role	8
	Loneliness/isolation/ depression	2
	Mental health immigrant women	3
	TOTAL	**25**
Day Care		11
	Child care for sick kids	1
	TOTAL	**12**
Housing		**9**
Poverty		**9**
Drugs/Substance Abuse		**9**
Nutrition		**7**

SURVEY FINDINGS

Only the three most frequently cited issues: family violence, in particular, violence against women; reproductive health, in particular, teen pregnancy; and mental health are dealt with in this section. These issues could also be used as a starting point to begin a more comprehensive approach to women's health concerns. Adopting several priority health strategies, might also make it possible to develop and coordinate a stronger inter-sectoral approach to women's health concerns.

• Family Violence

The majority of the key-informants (31 out of 37) cited family violence as an issue. Respondents said that violence against women happens daily in a variety of social settings. Those who work in transitional houses (four) said there is a growing number of women (and their children) seeking shelter in these houses. They and other respondents also added that:

- Few programs in the area of family violence are directed at the abuser or the potential abuser.
- Often when there are family problems, it is the woman, not the man, who is directed to seek psychiatric assistance or counselling.
- Violence against women is reinforced in the media; and the dominant message is that it is acceptable to abuse women. Both women and men are confused by these mixed messages.
- When a woman makes the decision to leave an abusive relationship, societal pressure for her to return is great, e.g. lack of money and support, demands from children, her spouse, the community and church to reunite the family.
- Evidence exists to demonstrate a correlation between women who were abused as children and women who continue to take on the "victim role" as adults. Many women who abuse alcohol/drugs also have a history of being abused. Yet little is done to break the cycle of abuse.

In conclusion, we are currently in a transition period in our understanding of how to stop wife battering. As Linda MacLeod, author of a land mark study on wife abuse[1] has so aptly said, "although we are driven by a strong, common hope to end this pervasive social problem, we have not reached a clear understanding of how to prevent violence against women in the home". She also adds that neither do we have "a unified sets of responses to address the problems which have emerged". Violence affects the physical and mental health of all family members, in particular women and children. The dignity and well-being of women should be considered as an action priority, says the Federal/ Provincial/ Territorial Working Group on Women's Health[2].

- **Reproductive Health**

Traditionally, reproductive health issues have been the "...major reason for women's use of the health care system" [3]. Due to their childbearing role, women have unique needs. In all, twenty-seven respondents raised reproductive health as an important issue. Most respondents tended to address an aspect of the reproductive health rather than to speak to the overall issues (see Table 1). To continue to illustrate the need for a comprehensive approach, teen pregnancy will be the focus for discussion.

Several key-informants had recently helped teen mothers in their communities and most adolescents lacked social support and were living in an impoverished state. Many teen mothers do not finish their basic education. Those who finish seldom go on to higher levels of education, unless they receive a lot of social support. For many young mothers and their children, a life of poverty is the predicted outcome. Without an adequate income "healthy choices" or "healthy environments" are unlikely.

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1 Macleod, L. (1989). Battered But Not Beaten: Preventing Wife Battering in Canada. Ottawa: Canadian Advisory Committee on the Status of Women, p. 1.

2 (1990). Working Together For Women's Health: a Framework for the Development of Policies and Programs. Prepared by the Federal/ Provincial/ Territorial Working Group on Women's Health, p. 7.

3 Ibid, p. 4

Young women who live on the streets are at risk of the AIDS' virus and/or using drugs. When they get pregnant, they also put their babies in the high risk category.

Teen mothers, who are poorly fed during pregnancy, have a higher incidence of low birth-weight babies. These babies are prone to other developmental problems.

Several respondents said community outreach support programs help these mothers. Examples of community outreach programs include: day care to encourage young mothers to complete high school; and programs which target teen mothers, such as "Pregnancy Outreach" and "Nobody's Perfect".

Many systemic biases, however, still exist for these young women. For example, to qualify for student loans in the post secondary education system, students must be full-time. In addition, many services are fragmented, poorly coordinated and inadequately funded. One obvious service gap is the period between "Pregnancy Outreach" and "Nobody's Perfect" programs. Several respondents indicated that many teen mothers and their children would benefit from continuous coordinated community support programs.

Several informants commented that birth control information does not acknowledge low literacy rate. They said that often the information is:

- presented in too complex a form;
- is not written in the person's native tongue;
- not always accessible;
- not readily absorbed (because of the person's state of mind); and
- is too costly and difficulty to access.

Preventing adolescent pregnancy requires education and accessible forms of birth control. Teens generally feel more comfortable speaking to peers, as they share similar perspectives and outlooks. The use of teen leaders to educate and to teach birth control is now more common. As with any age group, active participation in their health concerns, as well as in helping to find solutions, is important for adolescents. Most importantly it should be remembered that young mothers require specific forms of social support to

ensure a healthier outcome for themselves and children.

- **Mental Health**

Twenty-five participants cited mental health as an issue in the key-informant survey, making it the third most stated issue. As noted in the report Mental Health for Canadians: Striking a Balance [4] when trying to positively effect (women's) mental health, it is often the environment, not the individual, that is in need of change. The following comments from the key-informant survey illustrate this point further:

- The health care industry has been built up around women and the use of technology. This has sometimes contributed to women's health problems. Women visit doctors more often and take more tranquillizers and other medication than men.

- Often when a women visits her physician to seek medical advice, the control of the decision making is taken from her. Lack of control may have a negative effect on self-esteem.

- Clinics such as "Everywomen's Health Clinic" have been successful, in part, because the model of health services used allows women to feel both comfortable and in control.

- Control is kept in the woman's hands when she speaks to other women and shares similar health experiences with them.

- With the significant increase of women in the labour market and their continued house-work role, the burden which commonly falls on women has doubled. Few husbands take over the house-work role, at best some offer to help out. This burden is especially a heavy one for the "working poor".

This survey indicates that the mental health of women needs to be reconsidered. The literature indicates that one of the major public health problems facing developed countries today is mental illness[5]. When the entire area of stress and trauma are considered: family violence, extreme stress resulting from difficult life situations, women's poverty and consequent effect

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[4] (1988) Mental Health For Canadians: Striking a Balance. Ottawa: Health and Welfare Canada and the Minister of Supply and Services.

[5] Ibid.

mental health, the increasing number of illnesses associated with stress in the workplace, and the special problems of aging which have greater significance for women due to longer life expectancy ratios, mental health becomes the most critical issue for women.

Many women suffer from a great deal of stress, which is often related to their life situation and their inability to change it; many also turn to their physicians for help with their stress and other mental health problems. Often women are prescribed medications to help them cope with their unhealthy situation, rather than being advised and counselled on courses of action to change their environments, or to learn more effective coping skills[6].

- **Summary of the Key-informant Survey Findings**

In conclusion, the survey was a first step in the identification of relevant provincial women's health issues. The survey gives some indication (both from the willingness to participate and overall responses) that some people in British Columbia are interested, knowledgeable and already involved in a wide variety of women's health concerns. The survey also gives some indication that a more comprehensive approach to the planning and delivering of women's health programs is necessary.

This new approach would include such things as:

- enabling women to participate and represent themselves (as consumers, caregivers in the home and health providers in the system) in health decisions and by providing information and helping them to advance their level of education; and

- understanding and addressing the effect of larger societal trends on health, for example, the connection between poverty, education, nutrition, housing and health.

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[6] Rachlis, M., & Kushner, C., (1989). Second Opinion: What's Wrong With The Canadian Health Care System and How to Fix It. Toronto: Collins.

CONCLUSION

To effectively promote the health of women, it is necessary, however, to go beyond the sphere of an individual's ability to cope. From the analysis of the key-informant survey data, the author concludes that it also requires action such as:

- placing a priority on health policy that positively impacts women's health;
- focusing on prevention and health promotion;
- promoting active participation by women by developing services for women;
- increasing community awareness of the inter-relationship and inter-connection between women's health policy and other social policies aimed at improving women's status (e.g. child care, housing, wages and income maintenance, education, transportation, etc) and working to positively change these relationships; and
- using an multi-sectoral approach to health promotion, including dealing with systemic biases toward women, especially Native, immigrant, disabled women and young single mothers (e.g. education, wages, langauge, etc.).

There is a growing understanding of women's health needs in the community. When planning directions for women's health needs, the Ministry of Health might consider the findings of the key-informant survey. It is important to stress, however, that the findings from this survey are only a first step. While these findings add credence to the call for a new approach to health care for women, identification of relevant provincial women's health issues still requires further research and consensus building. It does seem that women's health needs will require a different approach. One which places greater emphasis on a community-based and health promotion focus; and provides for broad-based consultation with women and women's groups when planning direction.

In conclusion, participants identified several suggestions (Appendix 6) regarding immediate provincial priorities in women's health issues. They include:

- clarifying factors affecting women's health and identifying high risk populations (e.g. abusers);

- increasing awareness of women's health needs within the health care system;
- improving the quality of health services in meeting women's health needs, especially related to family violence, reproductive health and mental health;
- improving coordination and communications in responding to women's health needs;
- improving funding for projects which have demonstrated success; and
- building consensus on priorities for inter-ministerial action to improve women's health.

- APPENDIX 1 -

HEALTH DETERMINANTS FOR WOMEN

HEALTH DETERMINANTS FOR WOMEN (Appendix 1)

BROAD GROUPS	*RESPONDENTS COMMENTS*
Question	*What are the factors or situations that have the most important impact on women's well–being, both physical and mental?*
Health System	*The health care industry has been built up around women and inappropriate use of technology. This has contributed to women's health problems (i.e. over/misuse of tranquilizers). Women see doctors more often and take more medication than men. There are, of course, social reasons why this has happened more to women.*
	Equity of access: existence of cultural and language barriers. make it difficult to have equal access to services.
	Insufficient funding allocation for women's health.
	Misdiagnosis of women, especially psychological.
	Doctors are often not well informed about diets (i.e. doctors who insists that older woman should eat red meat to improve iron in blood when the woman has been a vegetarian all her life).
	Status and control issues with relationship to nurses in the work environment and the impact of this lack of control on nurses' health.
	Often when there are family problems it is the woman, not the man, who is directed to seek psychriatric assisstance.
	Inadequate provisions of supplies to care for family members at home rather than in institutions. All too often women are left with the burden of providing family member with care in the home.
	Pervasive use of sickness/illness model for health and a lack of a wholistic approach. Most decisien are made by doctors.
	Although there may be gaps in services, services are not always used by individuals.
	Need more flexibility in doctor/dentist clinic hours to accomondate the needs of working people.
	There is a dearth of pre/post natal prevention programs.
	Reproductive health choice is often lacking, especially in the North.

HEALTH DETERMINANTS FOR WOMEN (Appendix 1)

BROAD GROUPS	*RESPONDENTS COMMENTS*
Societal	*Women are schooled to believe what they are told and not to question authority.*
	At present women tend to settle for less; they seldom speak out about what is happening to them.
	Many women, especially young single mothers, often can not afford "healthy environments" for themselves and their children.
	There is an over emphasis of physical beauty of women in our society.
	Violence against women: many men and women still consider it the role of women to be subject of abuse.
	Violence against women is depicted a lot in the media; the dominant message is that it is okay to abuse women. Both women and men end up confused because of mixed messages.
	Education has made a difference in increasing self-worth and bringing about more positive experiences for women. However, there is a lot of gender bias in our language and literature and our daily interactions.
	People living in densely populated areas are subjected to a lot of "environmental pollution"; poor living conditions; and contact with with TB. In the Downtown Eastend of Vancouver a lot of places where people live do not have proper bathrooms for the disabled.
	Long standing power and economic differences between men and women.
	Lack of attention to helping people develop parenting skills.
	Women are not prepared to compete; we need more affirmative action to help women catch up.
	Immigrant women may lack langauge skills and be unaware that help is available.
	Women are often torn between raising children and the need to make money.

HEALTH DETERMINANTS FOR WOMEN (Appendix 1)

BROAD GROUPS	*RESPONDENTS COMMENTS*

So much of women's image has to do with physical beauty. When she is unable to perform a task because of physical disability, a woman is often left with an even lower sense of self-worth and value.

If a woman has an adequate income, she is more likely to meet nutrition and mental health needs of herself and her family.

Pay equity policies will help to address incomes of working women.

In marriage breakdowns, it is mostly women who end up living in poverty.

Role of women in caring for family is not respected until it is no longer provided.

Lack of equity of outcome -- Present funding allotment for "healthy communities" may not be addressing the need of the particular community (i.e. poor versus well to do communities).

There is a poor level of physical fitness and knowledge about health promotion and disease prevention in our society.

Dual role of women, little tax support for women staying at home, sandwich role of parenting (at both ends) are examples of societal expectations which increase women's stress and impact their health outcomes, especially their mental health.

When a woman's makes the decision to leave an abusive relationship, societal pressures for her to return are great: lack of money and support, and demands from children, husband, community and church to reunite her family.

There is evidence which demonstrates a correlation between women who were abused as children and women who continue to take on the "victim role" as an adult. Many women who abuse alcohol/drugs have a history of abuse.

In some communities poverty of Native people is emmense.

Legal system falls short of looking out for the interests of women -- usually women do not have a lot of success in the court system.

HEALTH DETERMINANTS FOR WOMEN (Appendix 1)

BROAD GROUPS	*RESPONDENTS COMMENTS*

If a woman accuses a man of abuse, her chance of gaining custody of their children decreases. Courts have a "friendly parent" rule which means the parent who seems to be the friendliest towards the other, while in court, gains custody.

Women lack appropriate power and control in community, profession and family. Few women are in decision making positions.

- APPENDIX 2 -

CHANGES NEEDED TO IMPROVE WOMEN'S HEALTH

CHANGES NEEDED TO IMPROVE WOMEN'S HEALTH(Appendix 2)

BROAD CATEGORIES	*SPECIFIC CHANGES*
Question	***What are the most significant changes that would lead to improvements in health and well–being of women?***
Health Care System	*Medical model which is the dominant one in present health system is a male model. It does not approach health problems wholistically.*
	Shift to a Health Model.
	Introduce primary health care model into system with different points of entry and a stronger focus on prevention.
	Change focus from crisis to outreach prevention and health promotion.
	Create a more wholistic system –– one that include midwives.
	Enhance the role of health unit with a broader wellness focus.
	Place less emphasis on technology and institutions.
	Use multidisciplinary team approach to health care delivery.
	Deliver services where people live and work.
	Put physicians on salary.
	At present services are very fragment (need more support and better coordination and counselling).
	Use a community development model to develop services for community.
	Need umbrella office to go to find out what is available in community.
	Reversal of trends to erode universal health care access (poor women and their children are having to pay extra fees).
	Change the health care system to include more self–help and women's collectives to assist with their health issues.
	Need quicker access to hospitals for women who have psychiatric problems and end up in transitional houses.

CHANGES NEEDED TO IMPROVE WOMEN'S HEALTH(Appendix 2)

SPECIFIC CHANGES

Need interministry colloboration and cooperation in all aspect of women's issues.

Shaughnessy Women's Health Centre provides a place to think about, to coordinate research and to address women's issues.

Control of health – idea that doctors are the only people who know what is best for women's health.

Start to work with women who have the greatest need, at all levels, and where they are at.

Have to try to service women in different ways which allow women to interact with other women about everyday problems.

Need more women in decision making positions.

Need to teach parenting skills even before conception.

To develop positive self-esteem needs to start with the very young.

Child Care issue has to be dealt with.

Address overt racism by educating professionals and immigrants

Health means different things to different people

Need to mentor women, to be there when they need help about such things as self-worth and eating disorders.

Change politics around health to involve women. Need women in charge of women's programs and need to give women a say in their health decisions.

Need one stop shopping for women which focuses on prevention and promotion rather than crisis.

Target programs at things impacting women's health: self-esteem, birth control, life planning, and finanical planning.

Sensitivity training for male dominated professions around women's perspective.

CHANGES NEEDED TO IMPROVE WOMEN'S HEALTH(Appendix 2)

BROAD CATEGORIES	*SPECIFIC CHANGES*
	Health of women and children has to be seen as an investment into our common future.
	Need to address violence against women including rape, battering child abuse and elder abuse.
	Women's power in community needs to be re-assessed and steps taken to empower and educate women. Important to remember the "herstory" of women's climb to decision making roles and positions of power. Don't let the rungs be pulled out for others who follow.
Education	*Target heallth education and information at a "grade 6" level and to specific groups rather than trying to reach everybody.*
	Educate physicians, government and women about women's health issues.
	Train doctors and other health professionals in health promotion and disease prevention .
	Train professionals around issue of violence against women.
	Teach women different basic nutritional meals using little money.
	Include feministic analysis in education. At present education is very gender bias against women especially in high school.
	Teach more respect for each others' similarities/differences and learn to celebrate uniqueness/differences, especially with relation to gender education.
	Need more innovative approach to education which goes beyond posters and pamplets.
	Pamplets are not the answer when people are unable to read them and/or understand them.
	Education such as family life programs do not address issues such as violence against women, rape or sexism.
	Need more counselling courses on stress, self-esteem, how to talk things out etc.

CHANGES NEEDED TO IMPROVE WOMEN'S HEALTH(Appendix 2)

BROAD CATEGORIES	*SPECIFIC CHANGES*
Legal	*Need to evaluate the "Young Offender's Act", especially as it influences the right of parents to parent.*
	More fairness in the legal system for women.
Housing	*Half-way house for pregnant teens (especially for those living on the street); and a recovery detox unit for teens coming of drugs.*
	Affordable housing to replace demolition of houses.
Native Women	*Native women need better opportunity to be accepted by society so so they can build a sense of positive dignity and self-worth.*
	Need more Native role models to help Native women develop a sense of pride in who they are.
	Develop programs that are culturally sensitive to Native women.
	More Natives working in government.
	Encourage and support health care careers for more Native peoples.
Immigrant Women	*Better access for immigrants -- qualified interpreters and accessible information.*
	Access to information in native language is essential.
	Address overt racism in our society.
Young Single Mothers	*Many of these women are living in poverty with their children.*
	Income is inadequate to make "healthy choices".
Disabled Women	*Health professionals need to focus not just on the women's disability, but also on the general needs of the person.*
	Better coordinated approach between medical profession and rehab. Too often the woman is torn between wishes of both groups rather what is best for disabled woman.
Community	*Build better recreation facilities for more active living.*

CHANGES NEEDED TO IMPROVE WOMEN'S HEALTH(Appendix 2)

BROAD CATEGORIES	*SPECIFIC CHANGES*
	More neighbourhood community health centres.
	Increase awareness of organizations in the community.
	More resources for single mothers to help mothers where they live.
	Increase funding for communities health promotion.
	Increase collective thinking around building healthier communities -- communities that are friendly towards kids.
	Increase healthy communities projects and include aspects of environmental issues.
Funding Allocation	*Base funding for programs which support women's health and help bring about positive changes in their lives.*
	Base funding for "husbands" programs to help stop the cycle of abuse.

- APPENDIX 3 -

SUCCESSFUL WOMEN'S HEALTH PROGRAMS

SUCCESSFUL WOMEN'S HEALTH PROGRAMS (Appendix 3)

BROAD GROUPS	*SPECIFIC SUCCESSES*
Question	***Could you describe successes or activities which have made a difference and have improve the well–being of women?***
Societal	*Contraceptive pill has lead to greater freedom for women.*
	More liberal approach to abortion.
	Women in the workplace has lead to increased economic independence for women.
	Increased access to university and professional training.
	Women are developing a greater sense of empowerment.
Women's Health Clinics	*Clinics in which a wholistic approach is used with the woman herself is in charge.*
	"Every Women's Health Clinic" has made a difference because women can go there and get the help which allows them to feel in control and be more comfortable.
Active Participation	*Maternal and child care is an example of consumers making a difference in the use of midwives and working to change medical practice.*
	Seniors actively picketting and demonstrating against selling drugs in Pigeon Park, Vancouver.
	Education rather than treatment; therapy programs that involve clients.
	Dealing with women's issues (i.e. PMS) helps women to deal with changes occuring in their bodies.
Attention to Teens	*Day care program for teens which they help to direct.*
	Banfield House for pregnant teens.
	Support group for teen mothers with pre/post natal education and drop in centre.

SUCCESSFUL WOMEN'S HEALTH PROGRAMS (Appendix 3)

BROAD GROUPS	*SPECIFIC SUCCESSES*
	Committee of community representatives to look into teen issues. (Uncertain if any teens are involved in the process).
Self-help	*Learning coping skills and supporting others:*
	"Voices" -- breaking the silence that heals the wounds. Self-help group to help survivors of child sexual abuse.
	"Intra Nous Femme" self-help approach to dealing with urban housing problems.
	Women speaking to women about their experiences -- grow strong together, increases peer support, decreases isolation and increases friendships.
	Self-help and infinity group for disabled women.
Community	*Raising public awareness of women's status:*
	Multi-cultural celebration for International Women's Day.
	Community Human Rights conference in which dealt with issue of racism.
	Family Week Celebration -- address relationship and how to build them.
	Seniors' Health Clinics -- deal with issues such as nutrition, use of drugs etc.
	First Night -- Community alcohol free New Years Eve celebrations.
	Newspaper column on health issues.
	Resturant Survey on healthy menu choices.
	Community survey on smoking policy discovered taxis with no smoking policies.
	Community forums that bring women together.

SUCCESSFUL WOMEN'S HEALTH PROGRAMS (Appendix 3)

BROAD GROUPS	*SPECIFIC SUCCESSES*
Partnerships	*Building new forms of partnerships in the community:*
	Railey Park Primary Health Care Model with community involvement.
	Working with city police to alert parents about teen's drug and alcohol abuse and telling parents where the family can get help to deal with problem.
	Physicians and Justice System working together to address family violence.
	BCMA, RNABC and the Radiation Branch of the Ministry of Health working together to get information to public about tanning beds and sun screening.
	RNABC helping UBC set up a course on community development for health professionals.
	Community Social Planning Committee which meets 9 times a year also acts as a Community Forum and a Network to get things done.
	In 1989 during a blinding blizzard, a group of about 130 professionals met to have a conference on "Family Violence". Although there was a lot of energy before and during the conference, unfortunately there no follow up.
Health Promoting Programs	*Programs that address the needs of immigrants and respect the different meanings of health.*
	Programs designed to help job skill development.
	On Loc Seniors Health Services in San Francisco.
	Abbey-Field Housing program for seniors.
	James Bay Wellness Project -- an outreach program for seniors.
	Teenage Life Skills programs.
	Work Orientation programs that help women re-entering the work force.

SUCCESSFUL WOMEN'S HEALTH PROGRAMS (Appendix 3)

BROAD GROUPS	*SPECIFIC SUCCESSES*

"Neighbour" Seniors program, in Vancouver.

"Activities are Good for Your Health" program to improve social connectiveness and social health of senior women.

"No-body's Perfect" program to teach parenting skills.

"Lunch" programs for Inner City School kids, in Vancouver.

"Mostly Muffins" program for chronic psychriatric patients. The individuals make and sell muffins at coffee time which leads to increase self-esteem. They also learn how to work as a team.

"Life After Birth" program that supports women who have post partum depression and helps young mothers through their pregnancy.

"Pregnancy Outreach" program to help mothers who are deemed to be at risk.

Community Outreach program to speak to teens about violence against women and date rape issues.

Treatment programs that have a strong interventionist approach have had a lot of positive results.

- APPENDIX 4 -

PRIORITIES FOR WOMEN'S HEALTH

POTENTIAL PRIORITIES FOR WOMEN'S HEALTH (Appendix 4)

BROAD CATEGORY	*SPECIFIC PRIORITY*
Question	***Given that health is a provincial jurisdiction, what should the provincial government's priorities be for action on women's health issues?***
Interministry	*Inter-sectoral approach to women's health issues which includes dealing with systemic bias towards women (education, wages, language etc) and a commitment to long term planning to deal with women needs.*
	Day Care services have to be made available because women are needed in the work force and can no longer afford to stay at home.
	Discuss openly the double burden of working women and the effect of this burden on women's health, especially for the working poor, and develop policies which support women's health ("healthy public" policies).
	Look to the Royal Commission on Reproductive Technology and set provincial strategies based on the findings.
	Work towards equity for women in the legal system.
	Improve coordination and communication with regards to policy makers responding to women's needs.
	Coordination of efforts on part of different ministries involved in services to disabled, Native and immigrant women.
	Increase welfare rates and minimal wage rates.
	Develop an intergovernmetal strategy to deal with violence against women that reaches the grass-roots level (go where people spend their time).
	Better representation of women in decision roles of government.
	Government should set tone for tolerance and positive race relations.
	Educational opportunities are needed to improve women's economic position. Systemic bias for women wanting to continue their education need to be dealt with.

POTENTIAL PRIORITIES FOR WOMEN'S HEALTH (Appendix 4)

BROAD CATEGORY	*SPECIFIC PRIORITY*
Ministry of Health	*Encourage and support the development of community–based clinics where women play a role in decisions concerning their own health.*
	"Health Promotion" – define what this concept means for women. The health model used has implications for women's health (i.e. non–smoking building).
	Develop policies which promotes healthy families.
	Need to promote public attitude that "I'm responsible for my own health" but ensure at the same time that "healthy public" policies are in place.
	Community–based approach to health which pays attention to vulnerable groups, needs of families and single women with children.
	Wholistic health planning which doesn't look at women in isolation but also considers family health issues and life experiences.
	At a fundamental level need to redirect funding priorities, especially to the community.
	Teen pregnancies have been identified as high priority need programs.
	Pay closer attention to relationship counselling and issues of self–esteem to improve health.
	Greater focus on children and need of parents needing to learn how to parent.
	Young childhood very important to formation of the person -- Healthy Schools programs will help.
	Create better information of available services (i.e. Information Clearinghouse System).
	Target women who are at risk rather than everybody. Work on more realistic, small chunks rather than taking on the world -- target.
	Find a better balance between "Teritary" care system and the rest of the health system.

POTENTIAL PRIORITIES FOR WOMEN'S HEALTH (Appendix 4)

BROAD CATEGORY	*SPECIFIC PRIORITY*

Carry out a review of services for women and make appropriate changes (child care, transitional houses, reproductive choices etc).

Ensure that program development includes all aspects of health (physical, emotional, social and economic).

Sufficient base funding to deal with women's health issues.

Fund health promotion projects with women's groups and association, women's networks and self-help groups.

Be prepared to double track for awhile when funding these initiatives. Need to spend money more wisely (not necessarily need more money).

Decentralize more decision by using grass-roots groups -- get a cross-section of community involved. Need to cover cost of travel for the grass-roots people.

Health education programs which focus on basic nutrition and hygiene, self-esteem etc and helps to promote healthier choices.

Support for the family to work through problems, especially Native family. Why do so many Native teens commit suicide?

Develop a strategy to deal with family violence. Abusive situations and issues are barely being addressed (reflected in the salary paid the Transition House workers). The growing numbers of women and their children who use these houses indicates the extent of this problem.

By themselves transitions houses are only bandaid solutions.

Native health isssues, especially substance abuse, need to be addressed.

Literacy, appropriate housing, and adequate income impact health and should have health considerations.

Immigrant women have special needs because many do not know how to access the health system. Many of these women do not speak English or it is not their first language.